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ABSTRACT

This practicum was designed to evaluate the needs of clinicians in identifying substance abuse issues in severely emotionally disturbed children and adolescents, and its dynamics in their family histories. This writer designed and administered pre and post questionnaires to both professional and paraprofessional staff members to evaluate attitude and feelings toward substance abusers; organized two group discussions to discuss perceptions of this population and knowledge about them; met with some staff members individually, and proposed psychoeducational needs for groups. Analysis of the data revealed that there was a lack of motivation in pursuing substance abuse histories unless there was a specific referral for that purpose. Clinical information was limited, and there was a realization that more needed to be done to address the needs of this population. Psychoeducational groups were implemented, self-help groups are now seen from a different perspective, and diagnostic protocols are being established. (Contains 34 references.) (Author)

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Increasing Clinicians' Diagnostic Knowledge Base By Development of Assessment and Evaluation Criteria for Severely Emotionally Disturbed Children and Adolescents With Substance Abuse Problems

by

Milton Burnett

Cluster 43

A Practicum I Report Presented to the Ed.D. Program in Child and Youth Studies in Partial Fulfillment of the Requirements for the Degree of Doctor of Education

NOVA UNIVERSITY

1992

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This practicum report was submitted by Milton Burnett under the direction of the adviser listed below. It was submitted to the Ed.D. Program in Child and Youth Studies and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

Approved:

October 21, 1992
Date of Final Approval of Report

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ABSTRACT

Increasing clinicians' diagnostic knowledge base by development of assessment and evaluation criteria for severely emotionally disturbed children and adolescents with substance abuse problems. Burnett, Milton T., 1992: Practicum report, Nova University, Ed.D. Program in Children and Youth Studies. Dual Diagnosis/Severely Emotionally Disturbed/Psychoeducational/Inservice Training/Psychoactive Substance Abuse/Self-Help Groups/Assessment And Evaluation/Children and Adolescents.

This practicum was designed to evaluate the needs of clinicians in identifying substance abuse issues in severely emotionally disturbed children and adolescents, and its dynamics in their family histories.

This writer designed and administered pre and post questionnaires to both professional and paraprofessional staff members to evaluate attitude and feelings toward substance abusers; organized two group discussions to discuss perceptions of this population and knowledge about them; met with some staff members individually, and proposed psychoeducational needs for groups.

Analysis of the data revealed that there was a lack of motivation in pursuing substance abuse histories unless there was a specific referral for that purpose. Clinical information was limited, and there was a realization that more needed to be done to address the needs of this population. Psychoeducational groups were inplemented, self-help groups are now seen from a different perspective, and diagnostic protocols are being established.

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CHAPTER I

INTRODUCTION

Description of Work Setting and Community

Community Setting

The institutional setting was in a predominantly rural state with a population of 1,085,200. It ranked 40th in the nation, as of the 1988 census, with the majority of the population in small towns. The 1988 per capita income for this state was $19,233. The largest industries in the state for that same year were in the service field which accounted for 23.3% of earnings, followed by durable goods manufacturing at 18.3%. The slowest growing of the state's industries for that year was the construction industry, which accounted for 19.5% of earnings. The fastest growing industry in the state was in the finance industry, insurance and real estate market. These three industries had a 6.0% increase for 1988, which showed growth of 16% over the past years.

The third major source of income for this state was its state--controlled liquor stores. In 1990, the state took in

$12.6 million in beer tax and a net liquor revenue of $55.9 million. Statistics show, however, that in 1988, alcohol and drug abuse problems in the state had cost the taxpayers an estimated $868 million. In dealing with the subject of child and adolescent emotional problems, it was interesting to note that there were a reported 25,000 alcohol and drug abusing teenagers in this state. The state was reportedly second in per capita consumption of beer in 1989, at 34.1 gallons. Its per capita alcohol comsumption was at 4.52 gallons annually, according to statistical information from 1990 reports.

The larger cities were in the southern part of the state and had been in a transitional phase for several years. This area had become more industrialized with the greater part being concentrated in the high technology sector industries. There had been a heavy emigration of people from other states over the past nine years but because of the deepening recession during the past two years in this area, this influx was now stopped and people were leaving the area. This small New England state was now facing a great deal of financial and budgetary restraints due to income loss, loss of industries and subsequent jobs and a declining tourist trade because of problems in other parts of the country.

The state hospital was located in the state's capital city with a population of 36,006. The state had a

Department of Mental Health and Developmental Services which had divided the state into ten mental health service regions, each had a community mental health center to provide services for the mentally ill as well as others requesting psychiatric services. These systems were reported to serve between four and five thousand clients a year.

The economic situation of the state at that time was bleak and was reflected in the state's major cutback in funds to the mental health system. That has also led to cutbacks in personnel and to declining services to some population groups.

Work Setting

The work setting for this writer was an acute care psychiatric unit for children and adolescents in need of assessment and evaluation, located in a free standing unit of the state hospital. These children were experiencing psychiatric, emotional, and behavioral problems.

Staffing Profile

The staff was a multi-disciplinary team which included child and adolescent psychiatrists, educational professionals, pediatric practitioners, nurses, psychologists, social workers, and specialists in rehabilitative services.

Population Served and Admission Process

The setting's population was composed of children and youth between the ages of six and eighteen who were initially in need of crisis stabilization and psychiatric or psychological services.

The child or adolescent was admitted to the program via four different processes, the first three of which are legal procedures. The first was an involuntary emergency admission (IEA). The IEA is processed against the child or adolescent if they are felt to be a danger to themselves or others. The second process was a commitment by the probate court, wherein the court maintains jurisdiction over the person for a period of time to assure that the services needed were provided. Third, was a court ordered evaluation and assessment for a child or adolescent who was in need of undetermined services at that point. The final process was one where the person admitted himself/herself on a voluntary basis.

Writer's Role

This writer's role was as a clinical social worker specializing in working with dual disordered clients. Dual disordered in that instance meant individuals experiencing an Axis I and Axis II psychiatric disorder with a concurrent psychoactive substance abuse disorder. Axis I and Axis II refers to the five axis multiaxial evaluation system of the Diagnostic And Statistical Manual of Mental Disorders, DSM-

III-R (APA, 1987). Axis I refers to patients with a primary psychatric disorder along with a substance abuse disorder. An example of this would be an adjustment disorder, attention-deficit hyperactivity disorder, and alcohol and/or marijuana abuse. Axis II is used for describing personality features, provisional diagnosis, and developmental disorders. An example would be a developmental disorder and/or Avoidant Personality Disorder. The writer's job is to provide individual and group therapy as well as assessment and evaluation of clients. Because of this writer's background and expertise in working with this population, he had been requested to look into formulating and implementing an evaluation and assessment program for the child and adolescent population.

CHAPTER II

STUDY OF THE PROBLEM

Program Description

The writer's work setting is an acute psychiatric hospital setting where children and adolescents were referred for evaluation and assessment which would be utilized to make recommendations for further treatment needs and/or placements. The major focus here was on psychiatric issues with a medical model framework.

A significant difficulty that was facing the facility was that the staff was unable to identify the major issue confronting the child and adolescent. The primary reason for this was that an incomplete and insufficient clinical history was being pursued. Was the problem a psychiatric one, a substance abuse problem, or was it a combination of both that was causing the child or adolescent to appear as having a major psychiatric and emotional problem?

This situation tended to complicate the clinical picture and resulted in incomplete clinical information for psychosocial evaluations which were utilized for subsequent referrals and recommendations. This had been a longstanding issue for administrators as well as some of the clinicians

who were becoming concerned with the repercussions as it related to inappropriate treatment and poor treatment outcomes. The problem that was currently confronting the hospital was its long-term neglect of the significance of the direct and indirect impact of substance abuse on its patient population.

Area of Difficulty

The difficulty that the hospital was faced with was that the clinicians, assigned to do the assessment and evaluation of these children and adolescents, did not have a clear understanding and working knowledge of substance abuse issues, its dynamics and its impact on a child's presenting psychiatric problems. None of the assigned clinicians currently had a state certification as a Certified Alcohol and Drug Abuse Counselor (CADAC). In brief, these children were not being fully and properly assessed and evaluated because of that lack of knowledge. There were some in the institution who refused to accept the impact that alcohol and drugs had on people in need of services.

As stated earlier, this has been a longstanding problem, one that extends to other treatment centers that were not primarily established to treat alcohol and drug problems, where professionals have a knowledge base as to the dynamics of substance abuse treatment. The major problem area was one of different treatment philosophies as well as different training processes. The antagonisms

evolved from the fact that drug and alcohol abuse counselors were not seen as professionals, but as para-professionals having "tunnel vision" as to what a person's problem was. Treatment professionals had primarily been separated by treatment modalities and settings with each having its own primary focus.

The problem that existed was the under assessment and evaluation of the effects of drugs and alcohol abuse problems on the child and adolescent population, related not just to childrens' and adolescents' personal use but how significant others in this environment were affecting them with their abuse and/or dependency on chemicals.

Problem Documentation

Evidence of this problem was supported by interviews with clinicians, the unit director, personal observations, clinical experiences, and from information from related literature. Interviews with the unit administrator indicated a concern with the staff clinicians' under assessment and evaluation of substance abuse histories, thus not providing appropriate evaluation for further referrals of treatment and placement needs.

Further evidence of the problem was illustrated in the concern shown by professionals for people who were presenting in different treatment settings in need of psychiatric help which was compounded by psychoactive substance abuse disorders. This had become an extensive

problem in some settings, creating financial and staffing issues that tended to strain the resources of the institution. There was a major focus nationally on what was described as the "Young Chronically Mentally Ill" client from 18 to 40 years of age who was considered dual disordered. The current research effort is being spearheaded by funding from the Robert Wood Johnson Foundation along with federal grant money. The writer's state had embarked on a major research project that focused on the assessment, evaluation and treatment needs of this population. The project was being sponsored by the foundation along with state monies, a collaborative effort with the state's major medical school and teaching hospital.

Treatment professionals had become aware of the lack of knowledge in how to deal with clients who were considered dual diagnosed, which was amplified in the treatment of children and adolescents experiencing emotional and substance abuse problems. Information from the current research on adults with substance abuse problems and comorbid psychiatric disorders was extrapolated for utilization with children where it was appropriate for the group. It was anticipated that an additional project would evolve for children and adolescents and consolidate the knowledge gained.

The writer's own experiences as a participant observer had demonstrated the neglect of some clinicians in obtaining

a sufficient alcohol and drug abuse history. In some instances there was ample evidence pointing to a problem with substance abuse, but it had been ignored as a major contributing factor in the clinical picture. The writer's interaction with clinicians had indicated that there was a lack of consideration on the part of some of these clinicians as to the impact that drugs and alcohol played in the patients' pathology and emotional disturbance. The neglect was not only related to the clinicians' training and professional orientation, but also to the clinicians' past and present experience with alcohol and drugs as well as their family history.

Causative Analysis

There were a number of perceived or possible causes to the problem presented. The first causative factor was a lack of and a need for a trained "hybrid" specialist to provide evaluation and subsequent treatment to this special group. Hybrid in this context means one who is trained in both substance abuse and mental health concepts. The need for the addition to the treatment staff of a specialized drug and alcohol abuse clinician left the evaluation process without appropriate professional input. Past experiences had shown that without a balanced staff, the assessment and evaluation would be a reflection of the person's training and therapeutic orientation. The problem had been compounded by a lack of literature and research relating to

children and adolescents with reported dual diagnosed disorders, as well as literature relating to treatment methods and programs.

Second was a singular concentration to evaluating and to treating the primary Axis I psychiatric diagnosis, to the exclusion of concurrent substance abuse disorder. Treatment seemed to be a focus of the clinician's training.

A third presenting issue was the long history of separate treatment modalities as well as a long history of the failure of provider systems and state agencies to bring the two services together. Because of conflicts between system approaches and professional antagonisms, services were fragmented and unsuccessful.

The fourth factor which had a major impact on the assessment and evaluation process was the clinicians' own prejudice which prevented them from addressing the issues of substance abuse. These prejudices often evolved from their own unresolved family issues relating to alcohol and drugs, as well as their own personal relationship with alcohol and drugs. In cases where this was relevant there was a tendency not to see alcohol and drug abuse as a major factor in treatment approaches.

A fifth causative factor that related to this problem was the need for psychoeducational programs to address the substance abuse disorders with adolescents and children on inpatient treatment units. These psychoeducational programs

needed to be directed to the clinicians' educational needs as well as clients.

A final causative factor was that there had been little interest in research that related to people with dual disorders; for a long period of time it was ignored, swept under the table. It is only in the past five years has this changed but most of this recent literature addressed the needs of the adult population; literature relating to the children and adolescent population was almost nonexistent.

Relationship of the Problem to the Literature

In looking at the need for better assessments, Gorman and Ross (1984) addressed the lack of in depth assessments of alcohol and drug abuse problems among a group of incarcerated juveniles as it related to the juveniles' own personal use and to the assessment of familial substance abuse. These assessments were not being provided on routine evaluation of the adolescent. Neglect of this aspect in the assessment of adolescents left a "gaping hole" in the treatment planning process. According to Chatlos (1989), this was especially important when the need for treatment of the chemically dependent adolescent was recognized and should have been a primary focus.

When considering the failure of clinicians to evaluate the family dynamics of alcoholism, Woodside (1983) pointed out the problem of assessment of parental alcoholism by clinicians and its impact on the child. She noted that

clinicians' prejudices, usually relating to their own family history of alcohol abuse which had gone unaddressed, interferes with the treatment process. Bogdaniak and Piercy (1987), in relation to this, pointed out that a significant number of youngsters in the Juvenile Justice System were children of alcoholics. These youngsters tended to experience a great deal of emotional and behavioral problems, usually exhibited in "acting out" behavior.

Looking at the effects of family alcoholism, Gorney (1989) had investigated the dual problems of chemical dependency and family violence. Gorney found that children from these environments suffer from school problems, personal problems, and problems with the law more than children who do not come from similar environments. These intergenerational issues and longstanding problems were only now being addressed to the appropriate degree they should.

The literature and research relating to the young adult mentally ill patient (18-40) with dual disorders (which most of the literature in this field is focused on) was, according to Galater, Castaneda and Ferman (1988), hampered by a lack of studies relating to this population. This deficit was even more glaring when epidemiological studies were sought for the adolescent and child dually diagnosed population. Ralph and Barr (1989) had also reported on the lack of literature dealing with the adolescent with dual disorders. They reported that the literature in this field

was not as prevalent as it had been in relation to adults.

In a study of adults with a concurrent psychiatric and substance abuse disorder, Osher and Kofoed (1989) reported that this can have a major impact on the person and can be crippling. Yet there had been a lack of studies addressing the treatment of this population, and the authors also showed even fewer studies in relation to adolescents. The problem was also one of fragmented and limited services according to Teague, McFadden and Drake (1989). These services, in order to be provided appropriately, had to first address the clinical and systemic issues which, in effect, act as a deterrent in most cases to providing appropriate services.

In researching the literature for monographs relating to the child and adolescent population experiencing dual problems, the writer found a significant amount written on this population as it relates to depression and the abuse of psychoactive substances. Some researchers saw depression and substance abuse as a major problem (Apple 1989; Joshi & Scott 1988; Deykin, Levy, & Wells 1987; Kashani, Keller, Solomon, Reid, & Mazzola 1985; Stefanis & Kokkevi 1986; and McConnell 1991). The issue of substance abuse and suicidality of children and adolescents was addressed by Levy & Deykin, (1989). The problem of depression and substance abuse in children and adolescents is hard to diagnose; one must look at what came first, the substance

abuse or the depression. Substance abuse can precipitate feelings of depression as well as thoughts of suicide.

In looking at a number of other disorders that the child and adolescent presents with in addition to psychoactive substance abuse, (Bukstein, Brent & Kaminer 1989; Jacobson 1988; Ralph & Barr 1989; and Shift & Cavaiola 1988) addressed a number of other presenting disorders such as attention-deficit hyperactivity (ADHD), learning disabilities (LD), conduct disorders, major affective disorders, antisocial personality disorder, anxiety disorder and children suffering from physical and sexual abuse. These disorders impacted greatly on treatment when superimposed over chemical dependency and/or abuse. In looking at the impact of these disorders Greenbaum, Prange, Friedman and Silver (1991) reported that comorbid substance abuse disorder was very prevalent among seriously emotionally disturbed adolescents, but again they showed that little research has been done with this population.

The literature on children and adolescents experiencing emotional and substance abuse problems addressed an array of psychiatric issues that children present with, but these studies were limited as to their scope in any one particular subject. This tended to limit the knowledge of treatment methods and modalities that the clinician could draw from for reference. The large amount of research that focused on depression in children and adolescents who were abusing

substances fails in most cases to take into consideration how depression presents at different developmental stages and age ranges. What would be considered depressive symptoms in late stage adolescent would not be so in the middle childhood stage. There were a number of issues confronting children and adolescents that needed to be a focus of research and one of these was the gap in the research literature as to the impact of environmental factors on children and adolescents and their abuse of alcohol and drugs relating to this, especially as it related to abusive families and violent neighborhoods some children must reside in. Another major topic that needed to be researched for this population group was their tendency to self medicate for the many different problems that ordinarily confront them, and along with this was their predilection to use substances to offset boredom. An important aspect of future research must be the adolescents use of alcohol and drugs as a developmental stage, their "right of passage", where this does not lead to addiction or any overt harmful effects. Because of the astronomical amounts of money being expended on treatment of children and adolescents with alcohol and drug problems, there is a tendency to find "pathology" where it does not exist.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUTION

Goals and Expectations

Goals and Expectations

The following goals and outcomes were projected for this practicum: The major goal of this project was to implement an assessment and evaluation protocol for psychoactive substance abuse in an adolescent and children's psychiatric population, and to propose an integrated treatment plan and program model for services.

The primary goal was for clinicians to have a greater understanding of and knowledge of the dynamics of alcohol and drug abuse issues as well as to be more sensitive to these issues, including both the patients' abuse, the parental and families' abuse, and how that can impact on the emotional issues of the child and adolescent. In working toward this, it was projected that administrators would see the need to provide staff with better training to evaluate substance abuse disorders and learn how to provide appropriate treatment in this modality.

Expected Outcomes

The following outcomes were projected for this practicum: (1) to provide diagnostic guidelines for a more precise and accurate clinical assessment that would present a broad overview as to the impact of alcohol and drugs on this population. The diagnostic guidelines would result in a quality evaluation for treatment recommendations and referral considerations. The suggestions would highlight a dual track approach.

The next projected outcome was (2) an understanding of the supportive help that self-help groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA) could be in the treatment process. These groups would be seen as an adjunct to the ongoing treatment provided by the institution and not as interfering with treatment.

The final expected outcome was (3) for administrators and clinicians to see the need for the implementation of a psychoeducational approach to address the issues of; shame, self-esteem, anger, communications, assertiveness skills training, living sober skills, guilt, stigma and the family dynamics of substance abuses. The expected outcome in relation to use of groups, would be the clinician's realization that these groups addressed the most salient aspects of child and adolescent life at that point and their remedial benefits would have a tremendous effect.

Measurements of Outcomes

The first evaluation process would be a self administered pencil and paper questionnaire that would be distributed to all clinicians involved with direct care of patients, as well as administrators, to determine attitudes/feelings toward alcohol and drug abuse and their perception of patients who abused substances. A pretest with a proposed time frame of two weeks for the test to be returned was to be used.

The second measurement criteria for assessment would be a workshop (to take place after the pretest had been administered) which would focus on clinical issues in patients experiencing problems with drugs and alcohol. That workshop would focus on issues of assessment and evaluation, family dynamics and how transference issues interfered in the process as well as treatment.

It is felt that by discussing the attitudes and feelings of the clinicians' at the workshop toward these questionnaires, assessment would focus on their responses to these questions, and how it impacts them, and how it relates to their work. At this point it would give the writer an opportunity to observe the non-verbal as well as verbal responses and the overall demeanor of the group. This approach was felt to be the most non-threatening, as there was some anger and resentment on the part of some of the clinicans to this writers presences and objectives.

The final measurement would be a pencil and paper self administered posttest to determine if there was an increase in the clinicians' awareness of alcohol and drug abuse issues and the dynamics and impact of substance abuse on children and adolescents. It was expected that a time limit of two weeks to complete and return the posttest was needed.

The formulation of questions on both the pre-and post-test questionnaire would be close-ended and would be comprised of yes/no and true/false statements.
These questions would be primarily value laden ones and would attempt to measure how the clinician perceived the alcohol and drug abuse problem and its ramifications. The questions chosen were also worded to determine the emotional feelings that are generated in the therapist when working with people who were experiencing problems with substance abuse. Did the therapist see the problem as one being primarily clinical or as a morality problem?

The development of these questionnaires was accomplished by the use of a number of instruments supplied to this writer by Rutgers University School of Alcoholism Studies (prior permission had been given to the university for replication of any material in their possession). Two instruments needed to be ordered directly from the authors and they were: "The Alcoholism Attitudes Scales Via Semantic Differential (Before/After)," by Ms. J. E. Jones, and the Alcohol Knowledge Questionnaire" pre-and-post test

by Dr. V. R. Miller. With the use of these sources as well as questions developed by the writer, both pre-and-post questionnaires were formulated. Included with the questionnaires was a demographic sheet which would give a encapsulated picture of who was responding out of the 35 distributed to the staff.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Solutions

Possible Solutions

In reviewing the literature for possible solutions, one must look at the problem situation again: The difficulty that was facing the hospital was that the clinicians assigned to do the assessment and evaluation of these children and adolescents did not have a clear understanding of the dynamics of substance abuse issues, and its impact on a child's presenting psychiatric problems. None of the assigned clinicians had a state certification such as a Certified Alcohol and Drug Abuse Counselor (CADAC). In brief, these children were not being fully and properly assessed and evaluated because of this lack of knowledge. There were even some in the mental health field who refused to accept the impact that alcohol and drugs had on people in need of services.

The major focus was on trying to get the staff clinicians to acknowledge that a lack of a complete and extensive substance abuse history impeded treatment, and to

accomplish this in a nonthreatening way. The approach taken was to focus on the innovations as an educational asset, one that would not be seen as a criticism of their current work. The major effort concentrated on the need for additional training and educational programs as well as the need for clinicians to look inward at themselves in order to improve their work with the substance abusing client, and their clients' families.

One of the primary solutions was better training in graduate schools for substance abuse issues, as well as ongoing training for those already in the mental health field. One of the major reasons why substance abuse information was lacking or at times nonexistant in the evaluation process was the professionals' lack of training in this field. Twerski (1989) attributed this to educational programs for psychiatrists, psychologists and other professionals as being neglectful in teaching subjects related to this field. If you look at the time these professionals spend in school from the graduate level on, from two to twelve years, this should make one ask the question------why the neglect-------why the disinterest? This writer's own graduate program did not have one subject on substance abuse. Ewan and Whaite (1983) reported the inadequate and poor evaluation of training programs for professionals in the substance abuse field along with poor follow-up to see what are the long-term gains in knowledge

base. The other concern that the authors addressed was the professional's attitude toward the alcoholic client and the need for further studies on this topic.

Googins (1984) looked at how social workers tend to avoid the alcoholic client. The author felt the only solution to this was improved formal education programs as well as education within the agencies and community with a change in agencies' policies on dealing with the substance abusing client. There was even less knowledge about cross-addiction and dual disorders. In attempting to correct this problem, we must begin to see the need for training and to see the substance abuse professional, as just that---a professional.

The need for additional training in the field of dual diagnosis is addressed Ridgley et.al. (1987) in seeing the need for the "hybrid" professional where both the mental health and substance abuse professional would have a knowledge of both disciplines; they would be cross trained to deal with both populations. The Ridgley et.al. report that the delivery of services to the patient population with dual disorders was wholly inadequate, with treatment concepts in an embryonic stage. This situation, if not resolved, would have extensive consequences.

In addition to the need for educational training in substance abuse issues, there was the issue of countertransference that had to do with the clinicians'

family history as it related to substance abuse, their own current use regardless of the degree and extent, and their own past use, (a past they may wish to put behind them, in some instances). The solution was for the clinician to be aware of this and address it at least intellectually if not in therapy. Woodside (1983) saw the clinicians' own issues with substance abuse interfering with the collection of data. Wegscheider (1988) saw the unresolved issues of the therapist as a major deterrent in treatment of the substance abusing client. She felt a great number of therapists are co-dependent and cannot be effective in treating clients if these issues remained unresolved. The author perceived this as a major factor in "burnout". Imhof, Hirsch and Terenzi (1983), reported that in the research literature relating to drug and alcohol abuse over the past 50 years, there was little mention of countertransference issues. In this writer's experience, this was one subject that clinicians often avoided, and then ignored the consequences. It was the clinicians' own denial and not the clients' which got in the way of treatment.

The other major countertransference issue in working with clients and their families who are experiencing problems with substance abuse, was the client's anger and confrontational attitude. Zimberg (1985) pointed out the difficulty in working with this population and the feelings the client can generate in the therapist.

The writer's own experience in dealing in supervision with therapists who were working with chemically dependent clients and were unfamiliar with their defensive structure of denial, rationalization, minimization, projection, belligerence and confrontational attitude was that these factors soon lead to feelings of frustration and anger toward the client. This reaction resulted in denying services to future clients experiencing the same problem because the therapist did not have the knowledge of how to handle this type of individual.

Description of Solution Selected

The solution to the practicum problem had as its major focus an educational process, one that was addressed directly by this writer in presenting a seminar on clinical issues dealing with the psychoactive substance abuser with severe emotional problems. The focal point of the seminar was the knowledge needed for appropriate assessments and evaluations of substance abuse, and of countertransference issues that might interfere with this ability. Only with the acquiring of this beginning knowledge can progress be anticipated. The knowledge base needed in working with substance abuse populations can only be gained by additional educational efforts. One of the results of the practicum will be providing program managers the educational tools and information as to what direction this approach should follow.

Report of Action Taken

The initial step in the practicum implementation, the administration of the pretest questionnaire, took place the third to the fourth week of January. The distribution of the questionnaire was within the hospital and given directly to the clinicians or placed in their mail boxes. These questionnaires were accompanied by a request that the forms be returned no later than mid-February.

The second phase of the implementation was the scheduling of the educational workshops during the second to the fourth week of February. Two formal workshops were presented, one for the professional staff and one to the para-professional staff.

It was during these two workshops that the particular feelings and attitudes that the staff had toward people with substance abuse problems were discussed. The extent of their knowledge base of working with people with addictions was looked at, as well as what they felt they needed in additional training to make their jobs easier. The pretest material was utilized to gain an understanding on the part of this writer as to what approach was needed during these sessions.

The third phase of the implementation was the administration of the posttest in March. All questionnaires were submitted to this writer by mid-March.

The final phase of the implementation took place at the

end of March through mid-April. This period of time was utilized to perform individual interviews for those clinicians unable to attend the workshops. The individualized interviews were also used as a supplement for additional time needed by other therapists on the unit requiring it, and for this writer to obtain information that would otherwise not be proffered on the questionnaires or in a group setting.

There were a number of individual meetings with staff members that took place off the premises, as well as several meetings with staff members that were unexpected. There was a desire on their part to talk and make their opinions known as to what this writer was trying to accomplish.

The negotiation for the permission for administration of the pre-and posttests was granted by the hospital Executive Director, as well as permission to institute a workshop for the educational objectives. It was felt that the workshop would be an appropriate time to explain the project to those who were not fully aware of it.

There were a number of meetings with the executive director throughout the entire implementation process to provide him with progress reports and to obtain feedback from him, and to discuss what he would like to see happen during this time.

One of the important aspects during the implementation process which would be utilized as an evaluation tool, was

the number of staff that would agree to participate in this evaluation process. It was projected that if participation was light, this would indicate the staffs antagonism. That they would resent this interference and be opposed to an outside investigator looking into their work. This writer felt that this unknown factor would be an important piece in determining the positive or negative results of the practicum by indicating the amount of clinicians interested in improving their assessment and evaluation skills. A lack of interest would also give evidence that additional efforts must be made to mandate improved skills and to impart to the therapist the importance that administrators were putting on improved diagnostic skills for alcohol and drug abuse problems. As was expected there was resistance to change and this information was used in the writer's discussion with the executive director, and the director has shown a major concern about this.

The final process of the practicum was to do an analysis and evaluation of all questionnaires during the month of April. It was at this phase of the practicum that this writer discussed with the executive director some of the impressions that had been formulated from the implementation period and the meetings with the staff. These included how the writer perceived the attitude and feelings of staff toward substance abusers as well as their overall perception of their work, and as to what changes the

writer felt were needed to be made in the program as it relates to substance abuse issues. It is expected that further contact with the executive director will be requested for additional programmatic input.

CHAPTER V

RESULTS, DISCUSSIONS, AND RECOMMENDATIONS

Results

The primary problem was the clinicians lack of a clear understanding and working knowledge of substance abuse, its dynamics and impact on children and adolescents. Consequently, the clinical staff was unable to identify the major issue confronting the child and adolescent, resulting in the inability to perform appropriate assessments and evaluations needed for treatment, planning, and referrals to other institutions and treatment professionals. The results were poor treatment outcomes, poor prognosis, and inappropriate treatment.

The solution strategies utilized to determine the extent of the problem and the approach that needed to be taken to impact a change were addressed. The first approach was the administering of the pre-questionnaire to see how the clinicians perceived the substance abuse issues and their attitude and feelings toward working with this population. The second was to meet with a group of professional staff members and, subsequent to this, a meeting with a group of mental health workers and nurses.

During this period of time, there were individual contacts with staff members and the executive director.

The groups and individual sessions were able to provide information as to how the clinicians perceived the writer's efforts, the need for improved diagnostic tools and training. The question, did they see the same issues confronting the hospital as the writer did, was analyzed.

The first questionnaire was used as the main tool to obtain the information as to the staff's knowledge base on substance abuse issues. Its benefit as a teaching tool was also discussed by the staff. The writer believed that this approach was non-threatening, and would not be perceived as intruding in their clinical work.

The final strategy was the administration of the post-test questionnaire which would be used primarily for evaluation of what the staff felt was needed by way of training to have a greater knowledge of psychoactive substance abuse. There would also be questions relating to attitude and feelings toward substance abusers.

The three projected outcomes were seen by the executive director as needed by the hospital to assure the best of service to its population. The three projected outcomes and there results are as follows: Outcome I is to provide diagnostic guidelines for a more precise and accurate clinical assessment that would present a broad overview of the impact of alcohol and drugs on the child and adolescent

population. It was expected that the diagnostic guidelines would result in a quality evaluation for treatment recommendations and referral considerations. The suggestions would highlight a dual track approach.

Outcome 1 has been addressed successfully with the administrator planning for a more indepth intake for the assessment and evaluation for psychoactive substance abuse. Testing instruments and informational questionnaires will be used in conjunction with this when appropriate.

The second projected outcome was an understanding of the supportive help that self-help groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA) could be in the treatment process. These groups would be seen as an adjunct to the ongoing treatment provided by the institution, and not as interfering with treatment. This outcome has been fully met by a number of adolescents being taken to one of the self-help groups in the community. There is still work to be done on implementation of additional groups geared more toward teenagers. The implementation of self-help groups in the treatment format has been ongoing, but the settings are geared for the adult. The staff will be looking at establishing or finding an already existing group where the major make-up of the group is adolescents. The one negative feature here is the skepticism that some professionals have toward self-help groups.

The third projected outcome was for administrators and clinicians to see the need for the implementation of a psychoeducational approach to address the issues of shame, self-esteem, anger, communications, assertiveness skills training, living-sober skills, guilt, stigma and the family dynamics of substance abuse. The expected outcome in relation to this would be the clinician's realization that these groups address the most salient aspects of the child and adolescent life at this point, and their remedial benefits would have a tremendous effect. The outcome has been met with partial success in that one group on substance abuse issues has been implemented, but other groups await further consultation by this writer or someone with a similar background before additional groups are started.

Discussion

There were 35 questionnaires distributed. They were dispensed to the professional and paraprofessional staff; this involved 35 in both the pre and postquestionnaires, (see table I). There were 19 prequestionnaire returned and 12 postquestionnaires returned (see figure I).

The assessment and evaluation of these questionnaires were graded on a "P" for a positive value and a "N" for a negative value. The positive factor indicated the person demonstrated a knowledge and understanding of substance abuse issues along with a positive attitude toward working with people experiencing a substance abuse problem. Those

Data:

Sample Set:

35 questionnaires sent (2 sets, pre, post)

Pre-questionnaire data: 19 returned, 7 Males, 12 Females

Profession	Frequency
MSW	3
NURS	5
TEACH	1
NA	1
PSYCH	2
MHW	3
OTR	1
TD	1
PU	2

Point of Recovery

In Recovery	1
ACOA	4

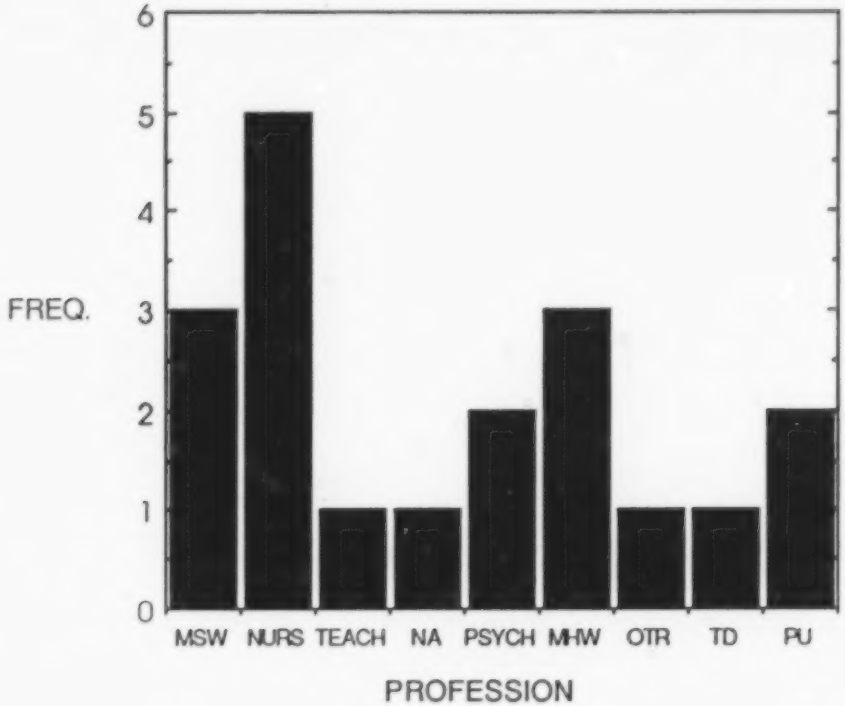
Post-questionaire data: 12 returned, 9 Males, 3 Females

Profession	Frequency
MSW	3
PSYCH	2
MHW	6
PU	1

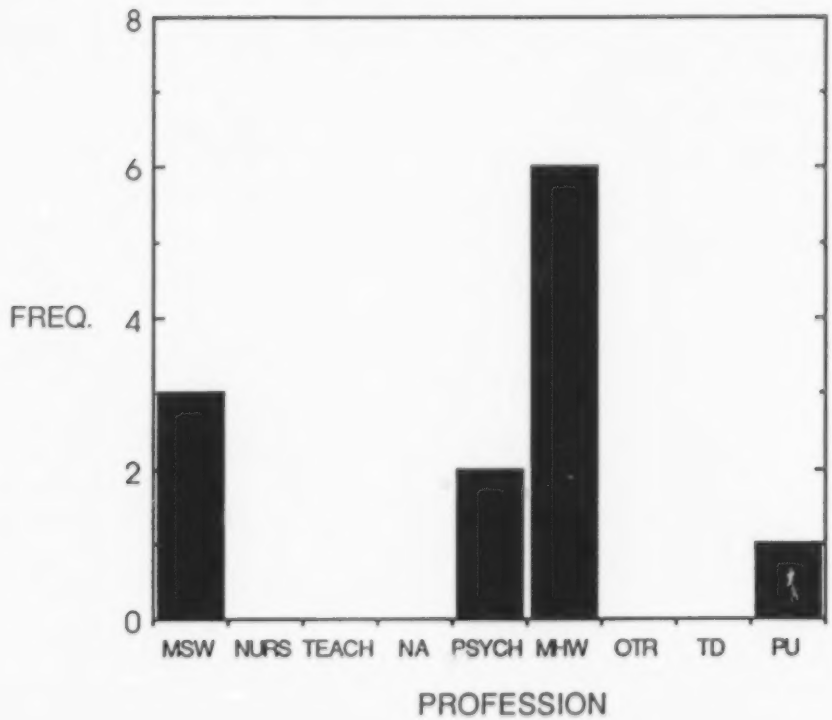
Point of Recovery

In Recovery	0
ACOA	1

PRE-QUESTIONAIRE DEMOGRAPH



POST-QUESTIONNAIRE DEMOGRAPH



given a negative factor rating indicated the opposite; they demonstrated very little understanding of substance abuse and its dynamics, and a poor attitude toward this treatment population.

When the writer analyzed the responses, he found that the entire staff indicated a very positive attitude toward people experiencing problems with substance abuse as well as a sensitive attitude toward working with this group. This positive response included every one of the 32 respondents.

The interesting aspect in light of the above information were the feelings that the staff displayed in the two group meetings. The group that consisted of social workers and psychologists gave the impression that, notwithstanding a basic knowledge of substance abuse issues, as a presenting problem, it was not perceived as one that was important to pursue unless a specific request on referral was made to evaluate for it. It was not seen as an important part of the evaluation and treatment process. To attempt to obtain this information without a specific request was seen as a violation of that person's privacy. There seemed to be an overall disinterest in the subject itself.

When looking at the second group, which was made up of mental health workers along with several nurses, they seemed to be very much interested in the aspect of looking at substance abuse and its dynamics and the part it plays in

their patients' lives. The nurses, especially, felt that not enough was being done to look at the substance abuse aspect; they felt this was a neglected issue. They talked about a substance abuse education group that was recently started, but were not comfortable with its management because no one on staff was trained to facilitate a group of this sort. This group felt they would like to have inservice training seminars on substance abuse issues.

Recommendations

First and foremost is the need for a more indepth intake on the assessement and evaluation for psychoactive substance abuse at the initial intake process, meaning an extensive longitudinal and cross sectional history. It is suggested that testing instruments and informational questionnaires would be used only as a supplement to this. The period of information gathering would proceed over an extended period of time. This is needed for all treatment and referral recommendations to proceed and to be processed appropriately. The administration is cognizant of this and is proceeding in this direction.

The primary intake history involves the patient at the outset which would be followed by a process of gathering information from ancillary informants, mainly family members, and depending on the case, this would include a number of systems and individuals who are involved with the child or adolescent. The ideal assessment would proceed

along the following format and protocol: The history information would be cross-generational involving as many of the actual family members as possible for direct information. When completed the history would display the following subheadings: Patient, father, mother, siblings, grandparents both paternal and maternal, maternal and paternal uncles and aunts, and great-grandparents, both paternal and maternal.

This particular format of informational gathering takes in the ecological perspective and enables the clinician to elicit a broad range of background information. This provides a complete developmental history of the individual as well as a family develomental history that will highlight major pathological issues. The ecological picture is much more reality and historically based then efforts to evaluate by testing instruments, the extent of substance abuse and emotional problems, which in and of itself does not give a clear and true clinical picture. A testing instrument or questionnaire that attempts to establish how much, how often, what drugs, what type of alcohol, and what frequency of use is not as important as what is going on in the childs' environment. The former can be a lot of clinical clutter, and an attempt at a short cut where none exists. If the extensive family history is followed a clear picture will develop, and point out what problem areas exist in the family structure, and how this is impacting on the

youngster.

The second recommendation is the self-help groups, and one that is of major importance is the peer support/self-help groups. The most well known would be the Student Assistance Program, a teen group format utilized in most high schools. This is most important with this age population. Self help groups such as Aloholic Annonymous (AA) have very few young people, and this acts as a deterrent to young members utilizing this as a helping group. This would not benefit these troubled youths, but in the long run be detrimental and of no lasting benefit. Most of these AA members would be at least one generation advanced and would tend to replicate the dysfunctional behaviors associated with their family background.

Narcotic Annonymous groups can be beneficial because there is a large group of teenagers involved in NA, but this association must be closely monitored. Some groups have seen problems occurring for several reasons, with some members being asked to leave the meeting places. A major reason for this is that the courts mandate people to attend these groups, which leads to people coerced into situations where resistance is rampant. The resistance has been in the form of drugs being brought into the meeting places.

To establish a Students Assistance Program can be accomplished by working in conjunction with the SEA person from the local high school. The idea here is to follow the

mainstreaming guidelines as is done in schools with handicapped/exceptional children. Students from local schools could be integrated into this program to help the hospitals' patients. This would be something both groups would look forward to.

Another important reason to look at the Students Assistance Program is not only because of the age difference in the regular AA groups. These groups also stress the fact that the affliction that is affecting you now is forever, that you will need the group for the rest of your life. This concept with the adolescent population sets in motion separation anxiety and tends to alienate the adolescent, since it continues them on the merry-go-round that they are trying to get off of. The statement "for the rest of your life" has a much broader meaning for the adolescent then for the adult.

The recommendation for psychoeducational groups would focus on a substance abuse didactic format and would present an overview of the addiction process and its ramifications from both an individual and a family perspective. The following format should be looked at: (1) the medical aspects of drug and alcohol abuse and how it affects the brain, the body, and the effects of chronic use along with the pathophysiolgical, and the psychopharmacological complications of substance abuse. (2) The family aspects of substance abuse and how it impacts from an intergenerational

level. (3) The psychological and emotional results of substance abuse and the defensive measures utilized to protect one from its damaging effects. (4) Nutritional aspects, and (5) AIDS the dangers of IV use.

Integrated within this structure would be additional groups that would address different psychological issues and enhance the teenagers' coping skills such as: Self-esteem groups, anger management groups, communication groups, social skills groups, assertivness groups, relapse groups, stress management groups, and stigma. These latter groups are all integrated into an overall conceptual frame work that can be interwoven into a school like curriculum. It is not neccessary to follow a sequential requirement, all tend to address immediate issues relating to psychoactive substance abuse by severely emotionally disturbed youngsters. We need to treat the whole person when it comes to substance abuse treatment and not the individual parts, as that results in fragmented and inefficient treatment.

The other educational need is for the training needs of the staff, and as stated above this has been requested by some. These topics will have to cover a wide array of subjects to meet the requirements needed to gain a working knowledge of substance abuse issues. The writer has discussed the possiblity of presenting workshops with the executive director and he is leaning favorably toward this suggestion.

Dissemination

The dissemination of some of the topics addressed in this practicum has been discussed with the state agency on alcohol and drug abuse prevention, especially the distribution of the questionnaires to different treatment centers around the state. The state agency has an interest in seeing how professionals around the state react to working with the substance abuse population, and especially as to how these attitudes affect women. It is also expected that this writer will be able to continue involvement with the hospital as it moves ahead on its planned innovative program proposals. Negotiations are now in the process with the administrator to define this new role. The writer has also discussed with the research unit involved with the adult dual diagnosed population an agreement to look over the practicum materials to see if there would be an interest in furthering the work already accomplished.

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APPENDIX A

PRE-QUESTIONNAIRE
ATTITUDES AND FEELINGS TOWARD SUBSTANCE ABUSERS

DEMOGRAPHIC INFORMATION

1. Male Female

2. Degree

3. Age

4. Position

5. Are you in recovery: YES NO

6. Are you an Adult Child of an Alcoholic (ACOA) or Drug Addict: YES NO

7. Religious Philosophy

   Protestant
   Catholic
   Jewish
   Fundamentalist
   Other

8. Political Philosophy

   Republican - Democrat
   Conservative - Liberal
   Independent
   Left of Center

Appendix A

Attitudes Toward Alcoholics and Drug Addicted Clients

Pre-Questionnaire

This questionnaire consists of 34 statements that would describe some possible attitudes toward alcoholics and drug addicts that people might have. Would you please circle one of the four possible answers that seems to convey your feelings.

A = Strongly Agree

B = Mildly Agree

C = Strongly Disagree

D = Mildly Disagree

There are no right or wrong answers, it is only your personal feelings toward this treatment population that is desired.

Also included in this questionnaire is a number of demographic questions that would be very helpful to me in completing my study. All information that is supplied will remain strictly confidential.

A B C D 1. I believe that alcoholism is a disease. (1.9)

A B C D 2. I believe alcoholism is a chronic disease. (1.42)

A B C D 3. My religion teaches that drunkenness is a sin. (1.41)

A B C D 4. Most alcohol and drug dependent persons are unpleasant to work with as patients. (1.40)

A B C D 5. Alcoholism is a self-inflicted disorder. (1.9)

A B C D 6. My parent's religious belief teaches that drinking is a sin. (1.42)

A B C D 7. Alcoholism is an incurable disease. (1.42)

A B C D 8. Alcoholism is associated with a weak will. (1.40)

A B C D 9. Alcoholism is a treatable illness. (1.40)

A B C D 10. I would be interested in working with alcoholics. (1.4)

A B C D 11. I like most alcoholics I have met. (1.4)

A B C D 12. Most alcoholics can control the amount they will drink. (1.4)

A B C D 13. Drug addiction is a treatable illness. (1.40)

A B C D 14. I believe that alcoholism is a sin. (1.42)

A B C D 15. Alcohol and drug abusers should only be treated by specialists in that field. (1.40)

A B C D 16. Paraprofessional counselors can provide effective treatment for alcohol or drug abusers. (1.40)

A B C D 17. With treatment, most alcoholics can learn to drink socially again. (1.4)

A B C D 18. AA is needed to recover from alcoholism and is an important part of treatment.

A B C D 19. Patients should be allowed to have AA/NA sponsors.

A B C D 20. Most alcoholics are indifferent to the suffering they cause. (1.4)

A B C D 21. An alcoholic is a person who cannot leave alcohol alone even for a day. (1.4)

A B C D 22. Although alcohol and drug abusers may be sick people, some firm punishment might help them grow up. (1.4)

A B C D 23. The problem of alcoholism and drug addiction can best be handled by the police and other law enforcement officials. (1.35)

A B C D 24. I am not especially interested in the problem of alcoholism and drug addiction. (1.35)

A B C D 25. The importance of protecting society from the alcoholic and drug addict cannot be overemphasized. (1.35)

26. Alcoholism and drugs as a problem for people served by your institute is in your opinion: (Circle One)

A. Minimal B. Moderate C. Severe D. No Information

A B C D 27. I accept alcoholics and drug addicts because they are sick people. (1.4)

A B C D 28. Alcoholism is an intergenerational disease.

A B C D 29. Alcohol and drug histories are not looked at as much as they should.

A B C D 30. The parents substance abuse impacts greatly on the child's behavior.

A B C D 31. I would feel uncomfortable if I had to be around alcoholic and drug abusing clients. (1.35)

A B C D 32. It would not bother me to have an alcoholic living next door to me. (1.35)

A B C D 33. Alcoholism is a sign of moral weakness.

A B C D 34. One of the biggest problems about alcoholism is the disgrace it causes to the alcoholics family.

(See footnote)

APPENDIX B

POST-QUESTIONNAIRE
ATTITUDES AND FEELINGS TOWARD SUBSTANCE ABUSERS

APPENDIX B

POST-QUESTIONNAIRE

This questionnaire is a follow-up from the first one you received. The first part of this questionnaire pertains to what you feel is important in training needs for you. The second part has to deal again with your feelings toward substance abusers.

Please circle the number (1-5) that best indicates how important the following resources or training on the following subjects are to you. Not all resources or training pertain to the substance abuse field. One = the least important and five = the most important.

DEMOGRAPHIC INFORMATION

1. Male Female

2. Degree

3. Age

4. Position

5. Are you in recovery: YES NO

6. Are you an Adult Child of an alcoholic (ACOA) or drug addict: YES NO

7. Religious Philosophy

   Protestant
   Catholic
   Jewish
   Fundamentalist
   Other

8. Political Philosophy

   Republican - Democrat
   Conservative - Liberal
   Independent
   Left of Center

Post-Questionnaire Survey

1 2 3 4 5 1.Information about alcohol (pharmacology, effects, etc.)

1 2 3 4 5 2.Information about other drugs (pharmacology, effects, etc.)

1 2 3 4 5 3.Children of alcoholics; family issues.

1 2 3 4 5 4.Strategies to programs to address the needs of high-risk youth.

1 2 3 4 5 5.Learning how to think and plan more creatively.

1 2 3 4 5 6.Marketing techniques.

1 2 3 4 5 7.Promoting healthy attitudes among those served.

1 2 3 4 5 8.Establishing goals and objectives.

1 2 3 4 5 9.Conducting a program evaluation.

1 2 3 4 5 10.Identifying local resources.

1 2 3 4 5 11.Managing conflict (1.40).

The following questions can be answered by indicating your opinion with A = Strongly Agree; B = Mildly Agree; C = Mildly Disagree; D = Strongly Disagree.

A B C D 12. It can be normal for a teenager to experiment with drugs.

A B C D 13. Recreational drug use precedes drug abuse.

A B C D 14. Marijuana should be legalized.

A B C D 15, Family involvement is a very important part of the treatment of alcoholism and/or drug addiction.

A B C D 16. Angry confrontation is necessary in the treatment of alcoholics and/or drug addicts.

A B C D 17. People who use marijuana usually do not respect authority.

A B C D 18. Alcohol is so dangerous that it could destroy the youth of our country if it wasn't controlled by law.

A B C D 19. Street pushers are the initial source of drugs for young people.

A B C D 20. Parents should teach their children how to use alcohol.

A B C D 21. Teenagers should not be allowed to smoke tobacco.

A B C D 22. Smoking leads to marijuana use, which in turn leads to hard drugs.

A B C D 23. Once a teenager becomes alcohol and drug free , they can never become a social user.

A B C D 24. I believe that alcoholism is a sin. (1.42).

A B C D 25. I feel my institute needs to have a percentage of its treatment program oriented toward alcohol and drug abuse issues.

A B C D 26. Special training is needed to implement drug and alcohol abuse counseling techniques.

A B C D 27. I wish I had more knowledge about alcohol and drug abuse issues.

A B C D 28. Would you like to have inservices on drug and alcohol abuse subjects.

A B C D 29. If funds for alcoholism control were made available to your department, would you recommend establishing an alcoholism program.

A B C D 30. A trained alcohol and drug abuse counselor is an important part of the staff.

(See footnote)

1

Author greatefully acknowledges the assistance of the Research Librarian at the Rutgers University School of Alcohol Studies for providing numerous,questionnaires that could be utilized in this Practicum. Numbers at end of question indicate the specific questionnaire used. Identification of source found in the references wth corresponding number at end of citation source.